

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER OR SUPPLIER ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) DATE COMPLETED	
W000	INITIAL COMMENTS The recertification survey was conducted from January 8, 2008 through January 10, 2008 using the full survey process. A random sample of two clients was selected from a residential population of three males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews, and a review of records, including unusual incident reports.	W000		RECEIVED DEPARTMENT OF HEALTH HUMAN SERVICES CENTERS FOR MEDICARE AND MEDICAID SERVICES ADMINISTRATION JUN 25 P 12:01	
W110	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that includes a separate record for each client. This STANDARD is not met as evidence by: Based on interview and record review, the facility failed to maintain Client #1's record by ensuring necessary consent forms were kept on file. The findings includes: Interview with the Qualified Mental Retardation Professional (QM) and review of Client #1's medical record on January 10, 2008 at 1:20 PM revealed the client had a colonoscopy on January 7, 2008. It should be noted that interview with the House Manager (HM) on January 8, 2008 at 12:31 PM revealed that the client did not have the capacity to give informed consent for the use of medication and/or medical services. The HM revealed that Client #1 had a grandmother that was involved in his life and would be the person responsible for giving medical consent. The HM was interviewed on January 10, 2008 to ascertain if consent had been obtained for the January 7, 2008 colonoscopy. According to the	W110	The Governing body seeks to ensure that its record keeping system meets the standards outlined in the policy and procedures relating to Client Records. The governing plans to do so by ensuring that a copy of all consents applicable to each individual is appropriately filed in their records for future reference. Client #1's grandmother signed the consent documents for him to have a colonoscopy. Provisions will be made to obtain a copy of the signed consent placed in his medical book. Client #1's grandmother is his limited medical guardian and this has been made know to the court.	1/24/2008	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be precluded from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes the findings stated above are disposable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disposable 15 days following the date these documents are made available to the facility. If deficiencies are cited an approved plan of correction is requisite to continued program participation.

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: P2LD11 Facility ID: 09G168

If continuation sheet Page 1 of 8

01/15/2008 01:33 FAX 2024429430

HRA

006/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 01/10/2008	
NAME OF PROVIDER (OR SUPPLIER) ST JOHN				STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W110	HM consent had been obtained however the consent form was submitted to the hospital at the time of the colonoscopy and there was no copy of the consent maintained in Client #1's record. At the time of the survey, the facility failed to ensure Client #1's record was maintained to make certain relevant consents were kept.	W110					
W120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meets the needs of each client.</p> <p>This STANDARD is not met as evidence by: Based on observation, interview, and record review, the facility failed to ensure that outside services meet the needs of one of the three clients (Client #2) included in the sample.</p> <p>The findings include:</p> <p>Observation of Client #2 at his day program on January 9, 2008 at 12:29pm revealed the client in a large room with approximately 23 other clients and 4 staff. The television was on and Client #2 was observed to be looking around the room. The client was not observed to be engaged in any constructive activity for 37 minutes (1:06pm). At that time, the client was observed to leaving the day program to go for a walk.</p> <p>Interview was conducted with the program director on January 9, 2008, to ascertain what activity the client should be engaged in during the aforementioned time frame (from 12:29 to 1:06). According to the director, the client, who had recently completed his lunch was scheduled</p>	W120	<p>The Governing Body seeks to ensure that all services provided by outside sources are obtainable and meets the needs of the individuals served.</p> <p>The QMRP completes monthly visits to each individual's assigned day program. The QMRP has set up a meeting with the assigned case manager, and Director to discuss #2's program activities. If #2's current placement is unable to provide him with structured activities another placement will be explored with him, his circle of support, and his assigned case manager.</p> <p>The QMRP will ensure that the program scheduled that is being followed is current and meaningful to the individual by completing monthly visits.</p>	<p>1/24/2008</p> <p>1/24/2008</p>			

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: P2LD11

Facility ID: 09G168

HRA

007/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER OR SUPPLIER ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 120	<p>Continued From page 2</p> <p>to engage in socialization activities in order to increase his socialization skills. The director further revealed that the client was provided with social skills training previously that morning and the time after lunch was used for the client to practice some of the training that was given that morning. The director verified the statement by providing a copy of the client's activity schedule for review. The activity schedule was dated for the months of September through December 2007. At the time of the survey, the facility failed to ensure Client #2's day program activity schedule was current.</p> <p>Continued interview was conducted with the day program's director to ascertain information on what the client was learning at the day program. The director provided the client's record for review and it revealed that active treatment documentation had ceased after September 30, 2007. Interview was conducted with the person responsible for documenting the therapeutic activities on January 9, 2008 at approximately 1:53 PM and he/she verified that the documentation was behind. At the time of the survey, the facility failed to ensure the day program's active treatment documentation for Client #2 was current.</p>	W120	<p>The QMRP will request reports during monthly visits to ensure that the documentation remains current and reflects the progress of the individual.</p>	1/24/2008	
W 124	<p>483.420(a)(2) PROTECTION OF CLIENT'S RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p>	W124	<p>The Governing Body seeks to ensure that the rights of all individuals served are protected. This is evident in their participation in self-advocacy groups every other month. The individuals in the home also facilitate Self-Direction meetings once a week. At the Self-Direction meetings the individuals discuss their rights and other topics of interest to them. This gives them an opportunity to express themselves and</p>		

HRA

008/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ 483 WING _____	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 01/10/2008	
NAME OF PROVIDER OR SUPPLIER ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W124	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the two clients (Client #1) included in the sample.</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #1's medical record on January 10, 2008 at 1:20 PM revealed the client had a colonoscopy on January 7, 2008. Continued interview was conducted to ascertain if consent had been obtained for the invasive procedure. According to interview with the House Manager (HM) on January 10, 2008, consent was obtained by the client's grandmother and was submitted to the hospital at the time of the scheduled colonoscopy. The HM further revealed that a copy of the consent was not maintained in the client's record. It should be noted that interview with the HM on January 8, 2008 at 12:31 PM revealed that the client did not have the capacity to give informed consent for the use of medication and/or medical services. The HM revealed that Client #1 had a grandmother that was involved in his life and would be the person responsible for giving medical consent. At the time of the survey, the facility failed to provide evidence that Client #1 or his legal guardian was informed of the invasive procedure (colonoscopy) including its attendant risks and consented to the procedure.</p>	W124	<p>voice their opinions.</p> <p>Client #1's grandmother signed the consent documents for him to have a colonoscopy. Provisions will be made to obtain a copy of the signed consent placed in his medical book. Client #1's grandmother is his limited medical guardian and this has been made known to the court.</p>	1/24/2008	
W159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W159			

FORM CMS-2567 (02-99) Previous Versions Obsolete

01/15/2008 01:35 FAX 2024429430

HRA

009/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER OR SUPPLIER ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	<p>Continued From page 4</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate each client's active treatment.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The QMRP failed to ensure the recommendation made by Client #1's nutritionist had been implemented and/or addressed. (See W460) 2. The QMRP failed to ensure Client #2's day program met his needs by ensuring his record was maintained with current information. (See W120) 	W 159	<p>The Governing Body seeks to ensure that each individual's active treatment program is integrated, coordinated, and monitored by a Qualified Mental Retardation Professional on an ongoing basis.</p> <ol style="list-style-type: none"> 1. The QMRP met with the staff in the home to discuss the nutritionist recommendations for Client #1. <p>The QMRP also contacted the nutritionist to schedule and in-service with the staff on the nutrition plans for all the individuals in the home. The nutritionist will complete an in-service with the staff on 1/27/2008.</p> <ol style="list-style-type: none"> 2. The QMRP has set up a meeting with the assigned case manager and Director to discuss #2's program activities. If #2's current. The QMRP will request reports during monthly visits to ensure that the documentation remains current and reflects the progress of the individual. 	<p>1/22/2008</p> <p>1/18/2008</p> <p>1/24/2008</p>	
W 322	<p>483.461(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventative care services, for one of the two clients (Client #2) included in the sample.</p> <p>The finding includes:</p>	W 322	<p>The Governing Body seeks to ensure that all individuals in the home are provided and obtain preventive and general medical care in accordance with the rules and regulations under Physician Services (a)(3).</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER OR SUPPLIER ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W322	Continued From page 5 Review of Client #2's medical record on January 10, 2008 at 4:34 PM revealed the client was last seen by the Audiologist on May 2, 2005. The audiological consultation form revealed that the client should have an annual evaluation, interview was conducted with the Qualified Mental Retardation Professional (QMRP) on January 10, 2008 at approximately 6:35 PM to ascertain if the evaluation had occurred. According to the QMRP, the House Manager had attempted unsuccessfully to get an appointment. At the time of the survey, the facility failed to ensure Client #2 received the recommended audiological services.	W322	The QMRP obtained an audiology appointment for Client #2 for March 4, 2008 at 9am.	1/25/2008	
W356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services, for one of the two clients (Client #2) included in the sample. The finding includes: Review of Client #2 records on January 10, 2008 at 4:45pm revealed Client #2 was seen by a dentist as documented below. December 29, 2006- dental consultant documented that the patient needed scaling. December 3, 2007-the dental consultant documented that the patient needed scaling.	W356	The Governing Body seeks to ensure that all individuals served obtain and receive comprehensive dental treatment in accordance with (W356) 483.460 (g) (2). The QMRP scheduled a dental appointment for Client #2 for January 29, 2008 at 9:30am with [REDACTED] for scaling. [REDACTED] received authorization to complete the cleaning.	1/24/2008	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008	
NAME OF PROVIDER OR SUPPLIER ST JOHN				STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W356	Continued From page 6						
	<p>Interview with the Qualified Mental Retardation Professional (QMRP) on January 10, 2008, at approximately 6:30 PM was conducted to ascertain if the client had the recommended scaling completed as documented on both of the aforementioned consultation forms. The QMRP revealed that the scaling had not been completed due to complications with pre-authorizations for the dental services. At the time of the survey, the facility failed to ensure Client #2 received the recommended dental services (scaling) in a timely manner.</p>		<p>QMRP will have the HM call before the scheduled appointment to ensure that the dentist has received authorization to have his scaling completed before he attends his appointment.</p>	1/25/2008			
W460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client received a nourishing, well-balanced diet including modified and specially-prescribed diets, for one of the two clients (Client #1) included in the sample.</p> <p>The finding includes:</p> <p>Observation and interview with Client #1 on January 8, 2008 at 4:18 PM revealed the client received crackers and apple slices with orange juice for a snack. It should be noted that client was observed to be of medium build with thin legs.</p> <p>Review of Client #1's record on January 10, 2008</p>		<p>The Governing Body seeks to ensure that each individual receives appropriate food and nutritional services based on their individual needs in accordance with the governing regulations of W 460 section 483.480 (a) (1) Food and Nutrition Services.</p>				
			<p>The QMRP met with the staff in the home to discuss the nutritionist recommendations for Client #1.</p>	1/22/2008			
			<p>The QMRP also contacted the nutritionist to schedule and in-service with the staff on the nutrition plans for all the individuals in the home. The nutritionist will complete an in-service with the staff on 1/27/2008.</p>	1/18/2008			

HRA

012/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER OR SUPPLIER ST JOHN				STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W460	<p>Continued From page 7 at 1:35 PM revealed the client's monthly vital signs chart that documented the client's weight from January 2007 through October 2007. According to the chart, the client weighed 138 pounds in January 2007 and weighed 128.2 pounds in October 2007 (9 months later). Continued review of Client #1's record on January 10, 2008 at 2:07 PM revealed the client's nutritional assessment dated April 18, 2007.</p> <p>According to the assessment, Client #1 was 68 inches tall (5'8") and had a desired body weight range of 124 to 164 pounds. Review of the client's nutritional quarterly dated October 31, 2007, revealed a recommendation that documented the client should be provided with "high calorie snacks twice a day (ice cream, regular yogurt, and pudding).</p> <p>Interview was conducted with the QMRP on January 10, 2008 at 6:05pm to ascertain if the recommendation by the nutritionist had been implemented and/or addressed. According to the QMRP, a meeting was held in December 2007 with the QMRP, the residential nurse, and the house manager (HM) at which time the Client #1's decline in weight had been discussed, however, at the time of the survey, the nutritionist recommendation to provide Clients #1 with high caloric snacks had not been implemented and/or addressed.</p>		<p>The QMRP informed the staff that Client #1 should be receiving high caloric snacks such as yogurt, ice cream, pudding twice in the evening; once when he arrives home and then again before he goes to bed. This will help increase his weight.</p>	1/22/2008		

HRA

014/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER OR SUPPLIER ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
1000	INITIAL COMMENTS				
1082	<p>3503.0 BEDROOMS AND BATHROOMS</p> <p>Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.</p> <p>This STATUTE is not met as evidence by: Based on observation and interview, the GHMRP failed to ensure bathroom were equipped with toilet paper and paper towel dispensers.</p> <p>The finding includes:</p> <p>Observations of GHMRP's environment and interview with the house manager on January 10, 2008 at 7:25pm revealed a roll of paper towel was housed in a shelf-like structure in the hallway bathroom located on the second floor. Further observation revealed there was no toilet paper and toilet paper holder (tube insert).</p>		<p>The Governing Body seeks to ensure that all bathrooms are equipped with toilet tissue, paper towels, a cup dispenser, and soap for hand washing.</p> <p>The QMRP informed the staff at their staff meeting about ensuring that all bathrooms have the needed amenities. Each bathroom has a toilet paper holder, toilet paper, and paper towels at all times.</p>	1/22/2008	
1206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been</p>				

HRA

015/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER OR SUPPLIER ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
I 206	Continued From page 1 performed and that the employee's health status would allow him or her to perform the required duties. This STATUTE is not met as evidence by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRRP) and review of the personnel records on January 9, 2008 at 4:58pm failed to provide evidence of current health certificates for two consultants.		The Governing Body seeks to ensure that all new employees and consultants have current health certificates that state their capabilities to perform their required duties. This is evident in the policy and procedure manual for the aforementioned agency. All consultants have current health certificates in their personnel records. The QMRRP obtained their information and placed them in their assigned personnel records.	1/13/2008	
I 271	3513.1 (b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request. This STATUTE is not met as evidence by: Based on interview and record review, the GHMRP failed to provide evidence of all staff's personnel records.		The Governing Body seeks to ensure that all administrative records are accessible to those agencies that need to view them upon request in accordance with the policy and procedures for Administrative Records I 271 section 3513.1 (b).		

01/15/2008 01:33 FAX 2024429430

HRA

016/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER (OR SUPPLIER) ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
I 271	Continued From page 2 The finding includes: Interview with the Qualified Mental Retardation Professional and review of the personnel files on January 9, 2008 at approximately 4:58pm revealed that the QMRP failed to provide evidence of personnel files for the one consultant.	I 271	All consultants have current health certificates in their personnel records. The QMRP obtained their information and placed them in their assigned personnel records.	1/13/2008	
I 401	3520.3 PROFESSIONAL SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the QMRP failed to ensure professional services were received in a timely manner, for two of the two residents (Residents #1 and #2) included in the sample. The findings include: Review of Resident #2's medical record on January 10, 2008 at 4:34 PM revealed the client was last seen by the Audiologist on May 2, 2006. The audiological consultation form revealed that the client should have an annual re-evaluation. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on January 10, 2008 at approximately 6:35 PM to ascertain if the re-evaluation had occurred. According to the QMRP, the House Manager had been attempting to get an appointment but had been unsuccessful. At the time of the survey, the facility failed to ensure Resident #2 received the	I 401	The Governing Body seeks to ensure that all individuals receive professional services in a timely manner in accordance with I 401 section 3520.3 General Provisions. The QMRP obtained an audiology appointment for Client #2 for March 4, 2008 at 9am.	1/25/2008	

HRA

017/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER (OR SUPPLIER) ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
I 401	Continued From page 3 recommended audiological services. 2. Review of Resident #2's records on January 10, 2008 at 4:45 PM revealed Resident #2 was seen by the dentist as documented below: December 29, 2006 - the dental consultant documented that the patient needed scaling. December 3, 2007- the dental consultant documented that the patient needed scaling. Interview with the Qualified Mental Retardation Professional (QMRP) on January 10, 2008, at approximately 6:30pm was conducted to ascertain if the client had the recommended scaling completed as documented on both of the aforementioned consultation forms. The QMRP revealed that scaling had not been completed due to complications with the pre-authorization for dental services. At the time of the survey, the facility failed to ensure Resident #2 received the recommended dental services (scaling) in a timely manner.	I 401	2. The QMRP scheduled a dental appointment for Client #2 for January 29, 2008 at 9:30am with [REDACTED] for scaling. [REDACTED] received authorization to complete the cleaning.	1/24/2008	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This STATUTE is not met as evidence by: Based on interview and record review, the GHMRP failed to ensure the protections of each clients rights, for one of the two residents (Resident #1) included in the sample	I 500	The Governing Body seeks to ensure that the rights of all individuals served are protected This is evident in their participation in self-advocacy groups every other month. The individuals in the home also facilitate Self-Direction meetings once a week. At the Self Direction meetings the individuals discuss their rights and other topics of interest to them. This gives them an opportunity to express themselves and voice their opinions.	1/10/2008	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER (OR SUPPLIER) ST JOHN			STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG I 500	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG I 500	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Continued From page 4</p> <p>The findings include:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of Resident #1's medical record on January 10, 2008 at 1:20 PM revealed the resident had a colonoscopy on January 7, 2008. Continued interview was conducted to ascertain if consent had been obtained for the invasive procedure. According to interview with the House Manager (HM) on January 10, 2008, consent was obtained by the resident's grandmother and was submitted to the hospital at the time of the scheduled colonoscopy. The HM further revealed that a copy of the consent was not maintained in the resident's record. It should be noted that interview with the HM on January 8, 2008 at 12:31 PM revealed that the resident did not have the capacity to give informed consent for the use of medication and/or medical services. The HM revealed that Resident #1 had a grandmother that was involved in his life and would be the person responsible for giving medical consent. At the time of the survey, the facility failed to provide evidence that Resident #1 or his legal guardian was informed of the invasive procedure (colonoscopy) including its attendant risks and consented to the procedure.</p>		<p>Client #1's grandmother signed the consent documents for him to have a colonoscopy. Provisions will be made to obtain a copy of the signed consent placed in his medical book. Client #1's grandmother is his limited medical guardian and this has been made known to the court.</p>	1/24/2008	

01/15/2008 01:33 FAX 2024429430

HRA

013/018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G168		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008	
NAME OF PROVIDER OR SUPPLIER ST JOHN				STREET ADDRESS CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
R000	<p>INITIAL COMMENTS</p> <p>The licensure survey was conducted from January 8, 2008 through January 10, 2008. A random sample of two residents was selected from a residential population of three males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs. Interviews and review of records, including unusual incident reports.</p>						